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ABSTRACT

Literature on women's roles suggests that those who don't marry are likely to feel like failures in the realms of relationships, work and independence. The clinic population studied found that 52% of the clientele under age 30 were single women. The research reported was aimed at better understanding this group of help-seeking women, and at developing clinical and societal strategies useful for this group. Help-seeking young single women in the clinic population studied were characterized by high rates of downward mobility (about one-third), and high rates of over-education for the jobs they held at the time of treatment (about one-third). They presented a cluster of troubles focusing around relationships, work and self-image, as well as personality troubles. Many felt like failures in various realms. Clinical and societal strategies are presented for both treating and preventing this cluster of struggles experienced by single women at this time of life. (Author)

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TROUBLED SINGLE WOMEN IN EARLY ADULTHOOD:
ISSUES AND STRATEGIES

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TROUBLED SINGLE WOMEN IN EARLY ADULTHOOD:
ISSUES AND STRATEGIES

Introduction

This paper presents a description of help-seeking single women in early adulthood, along with some clinical and societal strategies for dealing with those members of this population who conceive of themselves as failures. The widely shared values pressuring women to marry (discussed in Franzwa, 1975; Sales and Katz, 1976; Laws, 1976) suggest that those who don't will likely be placed in the painful position of feeling like multiple failures. They are likely to experience themselves as interpersonal failures since they have not found an appropriate partner; they are apt to feel like occupational failures since they have not been socialized to plan and manage long-term careers; and they are likely to feel like failures in the process of becoming adults since they have not been socialized to manage long-term financial independence. Sex discrimination in the work structure reinforces the sense of failure: women are apt to work in low-paying, dead-end jobs. For many, this means downward mobility comparing their current life-styles to those in which they were raised.¹ Some single women seek help in the midst of this complex crisis.

¹More than half of the Smith College students I have taught, for instance, expect to earn less money than do their fathers when they reach their fathers' ages. They expect to be downwardly mobile if they do not find a partner who has a more lucrative career than their own planned career.

This writer's clinical experience suggests that help-seeking single women in this age group do feel like failures regarding work and relationships, and that they also experience deep conflict over having to work. Independence, they seem to feel, should have been an option rather than a forced status.

The project reported was designed to determine what kinds of single women seek help in early adulthood, and what issues they bring with them. The purpose was twofold: to understand better the population under treatment, and to develop clinical strategies useful for this group.

Method

Subjects. Data were available on 248 clients of whom 90 were single² women, seen in individual, group, or couples therapy at a collectively operated mental health outpatient clinic in Cambridge, Massachusetts. The clinic serves a white, predominantly heterosexual middle class clientele who are in many ways similar to the 22 clinicians who see them. The latter are a mixture of professionals and paraprofessionals, ages 25 to 33, half male, half female.³

²"Single" refers to any person not living with a partner. Thus, all members of couples living together, whether gay or straight, married or not married, would be considered not single. Members of couples who are not living together are considered "single" in this report.

³The facility studied is a somewhat atypical clinical setting. Offices are located in the basement of a church, the setting is informal, and fees are largely negotiated according to the client's ability to pay. It is likely that the population served is somewhat different from that served in public outpatient clinics and other traditional psychiatric settings. The average fee paid is about \$15.00 per session for individual therapy.

The largest cluster of clients (about 70 percent) fall in the early adult age group (defined in this paper to include the years 18 to 29), clustering around age 25. Of these, most (52 percent) are single women, the majority of whom are seen in individual therapy (74 percent) by women therapists (68 percent). Other groups represented at the clinic include coupled women (24 percent), single men (23 percent) and coupled men (10 percent).

Procedure. Clinicians were asked to fill out a short questionnaire on each client they saw during a one-week period between early December 1976 and early January 1977. Eighteen of the clinicians (82 percent) did so. The data requested included demographic information (class, race, religion, usual and present occupation, education), treatment information (type of therapy, past therapy experience), sexual preference, presenting problems, and problems dealt with the week the questionnaires were filled out.⁴ In addition, coders assessed whether the clients appeared upwardly mobile, downwardly mobile, or stable (compared to family of origin) and whether or not the clients appeared appropriately educated for the occupations they had at the time of the study.

Findings

Demographic Characteristics of the Single Women Studied.

Class, Occupation and Education. Several aspects of these women's background suggest economic difficulty. While nearly a third (27 percent) were from upper-middle or upper class backgrounds,

⁴Since this was the holiday season, it was expected that respondents would be dealing with family issues to a larger extent than might be true at other times of year.

only 5 percent had graduate degrees (Masters level); while a large cluster (39 percent) were working at jobs which required substantial skill, post-secondary training, or a college degree (teacher, performing artist, ccounselor, nurse, etc.) these jobs were not apt to provide incomes in keeping with the economic backgrounds of the upper middle class group. Only one woman was working at a professional level (requiring graduate training). Many (about 16 percent) were currently working at jobs which required less skill than their usual occupations. (While 55 percent fit the semiprofessional category regarding their usual occupations, only 39 percent fell into this category when current occupations were examined; the rest were doing work which required less skill.) Finally, a large proportion (37 percent) appeared overeducated for the work they were doing at the time of the study (many of the latter were women with some college training doing low-pay, low-skill work).

What emerges here is a picture of a clinical population with many economic troubles. (Whether or not individuals feel these economic pressures will, of course, vary from person to person.)

Sexual Preference and Religion. About 90 percent were heterosexual, 4 percent were bisexual, and 3 percent were homosexual. About 40 percent were Jewish, 32 percent were Protestant, and 28 percent were Catholic.

Therapy Variables. Most of these young adult single women (83 percent) were in individual therapy. About 12 percent were in group therapy, and 5 percent were in couple therapy. In a few

cases an individual was in more than one kind of therapy, most often in group and individual treatment simultaneously. About half the group (49 percent) had had some kind of therapy prior to coming to the clinic. Finally, about 13 percent had been hospitalized for psychiatric reasons prior to the current treatment.

Presenting Problems and Current Problems. The discussion of the failure syndrome in the introduction to this paper suggests that women might come to psychotherapy for reasons relating to multiple personal failures--work troubles, life-planning troubles, poor self-images, and relationship troubles. Table 1 (see page 6) presents the list of issues coded, rank ordered according to the percentage of clients presenting that issue at the start of therapy, and the percentage working on that issue during the week studied. Items marked with an asterisk are those expected to come up most often.

While the items discussed do not appear as often as might be expected, they do tend to occur more frequently than many other items. The fact that a number of the predicted issues do come up lends support for the development of clinical strategies for dealing with them.

Discussion

The picture presented above suggests that along with the range of issues presented in any clinical population (focused on personality troubles--depression, anxiety, feeling out of touch, indecisiveness, etc.), there is a cluster of issues presented by young adult single women relating to social and economic failure.

TABLE 1

ISSUES PRESENTED AND ISSUES WORKED ON DURING THE WEEK STUDIED^a

Percentages of Clients Mentioning Each Issue Rank-Ordered			
<u>Presented at the Start of Therapy</u>		<u>Worked on During the Week Studied</u>	
Personality Troubles (depression, anxiety, etc.)	38.9	*Specific Relationships (friends, lovers, etc.)	31.1
*Generalized Relationships ("people," "men," etc.)	31.1	Personality Troubles (depression, anxiety, etc.)	22.2
*Specific Relationships (friends, lovers, etc.)	27.8	Relationships with Family of Origin	22.2
*Work Issues (work identity, day-to- day coping, job changes)	25.6	*Work Issues (work identity, day-to- day coping, job changes)	21.1
*Self-Image (hates self, body)	18.9	*Life Plans, Life Tasks (long range)	14.4
Relationships with Family of Origin	17.8	*Self Image (hates self, body)	14.4
Loneliness	15.6	*Generalized Relation- ships ("people," "men," etc.)	11.1
*Life Plans, Life Tasks (long range)	14.4	Specific Expressiveness Issues (assertiveness, expressing feelings, etc.)	7.8
Coping with Loss (of relationships, self)	10.0	Coping with Loss (of relationships, self)	5.6
Physical Symptoms (anorexia, insomnia, etc.)	8.9	Sexuality (specific sexual issues, sex identity, etc.)	3.3
Sexuality (specific sexual issues, sex identity, etc.)	7.8	Loneliness	3.3
Generalized Dissatisfaction	7.8	Coping with Changes (new home, town, job, etc.)	2.2
Coping with Changes	4.4	Physical Symptoms (anorexia, insomnia, etc.)	2.2
Suicide Issues	1.1	Generalized Dissatis- faction	0.0
Specific Expressiveness Issues (assertiveness, expressing feelings, etc.)	1.1	Suicide Issues	0.0

^a Asterisked items are those expected to come up most often.

While individuals within this group experience the syndrome to varying degrees, it is useful to sensitize clinicians to these troubles which appear quite often in a cluster.

This writer's work with individuals who feel like multiple failures reveals several themes in these women's lives. First, work and interpersonal relationships are so closely linked that when the latter are painful; the client's ability to work is greatly impaired. The need for approval from men for career pursuits found in studies of career aspirations among college women (Almquist and Angrist, 1971, and Tangri, 1972, both cited in Laws, 1976) seems to find its most painful support in the day-to-day lives of this group. Without the support of a male partner, life seems more difficult than it ever should have been. Men come to be defined as "the answer" to the multiple problems of adulthood. Second, not only do these clients struggle with the day-to-day and long-range problems of anyone in a career; they also struggle with anger and disappointment at having to work since they have imagined that they wouldn't have to do so. Finally, not only do they struggle with the loneliness inherent in the status of being single; they also struggle with the stigma of having failed at their primary goal--marriage.

Clinical Strategies. Successful work with these kinds of clients includes: (1) Facilitation of the grief process by encouraging them to express whatever feelings emerge related to their situation (loss of childhood, anger and sadness at having to take care of oneself, anger and sadness at feeling lonely, loss of fantasies of living happily ever after, anger at feeling

deceived by society's fantasies, etc.); (2) Confronting the client with the realities of the wider economic system (i.e., you have to work in order to eat; good jobs are difficult to find; women are discriminated against in the occupational structure; if you want to be living in a particular life-style you'll have to take responsibility for making it happen, etc.); (3) Helping the development of positive self-images as single women by reminding them that marriage is not the long-range answer to emotional difficulty (citing data if necessary); (4) Demystification of "partners" as the solution to all of life's problems (i.e., even if you were coupled you would still have to manage your career); (5) Helping the client realize that she has the power to plan and control numerous aspects of her life without waiting any longer for Mr. Right to help her do it (or do it for her); (6) Helping the client find alternative ways of getting her social, emotional and physical needs met (developing friendships, joining groups or activities, learning to enjoy masturbation).

Societal Strategies. The sociology of work shows that women who work outside the home have more power in their families and enjoy better mental health than do housewives (Udry, 1972; Bernard, 1972). Cross-cultural studies suggest that when women's and men's occupational roles are similar, women enjoy higher public status than they do when their roles differ (Sanday, 1974). There is strong support for the prediction that equality in the work force would provide more power for women. This in turn would very likely contribute to the development of more positive self-images and to general emotional well-being, especially among women who

were feeling dissatisfied with other aspects of their lives. It is this writer's opinion that the sense of failure experienced by single women in the early adult years would be greatly alleviated by a number of changes both in the work structure and in the ways women are socialized to approach work.

These changes include: (1) Elimination of career stereotypes in the early socialization process via nonsexist textbooks, TV and radio programming, magazine advertising, magazine fiction, children's books, etc. (2) Emphasis, via these same communication channels, on the fact that every adult is expected to work, even housewives. This would include a focus on the complexities, drudgeries, joys and frustrations of housework and motherhood as an occupation, including the fact that this work is worthy of whatever remuneration it would cost to hire someone to perform the tasks involved. (3) Establishment of social support for nonmarriage, late marriage, and career and marriage combinations as viable life-styles (via textbooks, media, etc.), emphasizing that single women are in some ways healthier than are married women. (4) Establishment of effective affirmative action programs.

This writer assumes that wider social and economic policy directly affects women's mental health. The emotional and occupational failure state of many single women is just one aspect of this wider health issue.

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